

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/07/2012
NAME OF PROVIDER OR SUPPLIER  MABRY HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1340 N GRUNDY QUARLES HWY P O BOX 7 GAINESBORO, TN 38562		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  An annual Licensure survey and complaint investigation #29519 was completed on June 7, 2012, at Mabry Health Care and Rehab Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

*Ruthless M. Graves*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

*Adm*

(X6) DATE

*6/19-2012*

STATE FORM

5599

W4VF21

If continuation sheet 1 of 1

JUN 21 2012